STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING _____ B. WING _____	02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY PLACE OF SOUTH BEND	52654 NORTH IRONWOOD ROAD SOUTH BEND, IN 46635

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F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. Survey dates: January 30, 31, February 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10, 2011 Facility number: 000124 Provider number: 155219 AIM number: 100266730 Survey team: Becky Luft RN TC (January 30, 31, February 1, 3, 4, 7, and 8, 2011) Toni Krakowski RN Vicki Manuwal RN (January 30, 31, February 1,3, 4, 7, 8, 9, and 10, 2011) Census bed type: 119 SNF/NF 119 Total Census payor type: 18 Medicare 72 Medicaid 29 Other 119 Total Sample: 24 Supplemental sample: 10 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on February 17, 2011 by Bev Faulkner, RN	F 000	F 000 The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correction of conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Correction a condition to participate in the Title	3/12/11
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

RECEIVED
MAR - 4 2011
LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joseph Shuler	EXECUTIVE DIRECTOR	3/3/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident, who was totally dependent for her needs, was assisted with eating her morning meal. This deficient practice affected 1 of 4 residents who require assistance with eating in their room in a sample of 24. Resident: # 14 Findings include: Resident # 14's clinical record was reviewed on 2/01/11 at 9:30 a.m., and indicated diagnoses of, but not limited to: debility, rheumatoid arthritis, and dysphagia. Resident # 14's Admission MDS (Minimum Data Set) assessment, date 12/14/10, indicated she was totally dependent of one person assistance for eating. A Care Plan, dated 12/07/10 and updated 12/30/10, indicated, "Problem: (Resident's Name) is at risk for wt (weight) loss R/T (related to) TF (tube feed), poor intake, malnutrition, wounds...puree pleasure feeds per res (resident) tolerance...Approach: ...5. Monitor tolerance to diet...13. Provide diet as ordered...." During observation of Resident # 14 on 2/03/11 at	F 241	18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. F 241 1. Resident #14's breakfast tray was heated and staff assisted with her meal. 2. Residents requiring total assist with meals will be fed when all room trays have been served. 3. Staff have been re-educated on hall trays. Residents who are dependent for meal service have been identified. Any non-compliance of nursing staff will result in 1:1 re-education up to and including progressive discipline. Nursing managers or their designees will monitor hall trays daily for 2 weeks, 5 days for 1 week, 3 days for 1 week, and then weekly thereafter. 4. Audits will be presented to the Executive Director for review. Results of audits will be presented to the Performance Improvement Committee monthly for further educational or monitoring recommendations.	3/12/11

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F 241	Continued From page 2 9:20 a.m., a food tray was observed resting on the bedside table. The tray contained a bowl of scrambled eggs, a bowl of oatmeal, a glass of water, and a glass of orange juice. The food and drinks on the tray were observed untouched. Resident # 14 stated in an interview at the time of the observation, "They said they were going to come back to feed me, but they never did." She further indicated it had been at least an hour, "It was whenever they delivered my tray." Unit Manager # 5 indicated in an interview on 2/03/11 at 9:25 A.M., morning breakfast trays were passed to the residents between 7:00 and 7:15 A.M. that morning. When queried why Resident # 14 was still waiting to be fed two hours later, she stated, "She gets pleasure feedings. She has a feeding tube." During interview with the Director of Nursing on 2/05/11 at 11:45 A.M., she indicated Resident # 14 should have been fed her breakfast tray by the aide that delivered the tray.	F 241		
F 272 SS=D	3.1-3(t) 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information;	F 272	F 272 1. Resident #46 was re-assessed and no negative outcomes from the fall were noted. 2. Residents who sustain an un-witnessed fall will have a neurological assessment completed per policy within 72 hours.	3/12/11

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F 272	Continued From page 3 Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure neurological monitoring was completed for a resident who hit his head when he sustained a fall. This deficient practice affected 1 of 12 residents reviewed for falls in a sample of 24. Resident: # 46 Findings include: Resident # 46's clinical record was reviewed on 1/31/11 at 2:55 P.M. and indicated diagnoses of, but not limited to: intractable epilepsy, seizure disorder, and mild closed head injury.	F 272	3. Nursing staff have been re-educated on when to complete a neurological assessment. Event reports will be brought to the Daily stand-up meeting (Monday through Friday) for review and recommendations, and to assure that neurological assessments have been initiated. Any identified non-compliance will result in 1:1 re-education up to and including progressive discipline. 4. Audits will be presented to the Executive Director, and reviewed monthly by the Performance Improvement Committee for further education or monitoring recommendations.	

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F 272	Continued From page 4 Review of Nurse's Notes, dated 1/09/11 at 7:45 A.M., indicated, "CNA (Certified Nursing Aide) reported res. (residents) roomate (sic) said he heard this loud noise in bathroom. Upon arrival to res. room, found res. lying in bed with eyes closed. Roomate (sic) said he heard loud noise in bathroom, he called him (Resident # 46) by name, but no response, he only saw one of his hands on the floor. Spoke with res. who was easily aroused states he remembered going to bathroom. He remembered hitting his head. No redness or bruising noted to head. No bruising or redness to body...Res. said he really doesn't remember what happened. (temperature) 97.8, (pulse) 78, (respirations) 18, BP (blood pressure) 126/77." Resident # 46's most recent quarterly MDS (Minimum Data Set) assessment, dated 1/04/11, indicated he was cognitively intact. Further review of Resident # 46's clinical record lacked documentation to indicate vital signs and neurological monitoring for 72 hours post fall involving hitting head. During interview with the Director of Nursing on 2/03/11 at 2:20 p.m., she indicated neuro checks were not initiated because she wasn't convinced the resident actually sustained a fall. A facility policy titled "Neurological Evaluation," revised 10/31/10, indicated, "Rationale: Neurologic vital signs supplements the routine measurement of temperature, pulse rate, and respirations when a patient is suspected to have hit their head (e.g.., a fall), has hit their head or has a traumatic brain and/or spinal cord injury...2. ...In the event that a specific order cannot be	F 272		

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F 272	Continued From page 5 obtained or until the physician can be notified, begin with the following time frames: every 15 minutes for a hour, then; every 30 minutes for a hour, then; every hour for 2 hours, then; every 4 hours until physician states it is no longer necessary or in 72 hours if patient's condition is stable and showing no signs and symptoms of neurological injury...." 3.1-31(c)(2)	F 272		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow physician orders related to the administration of insulin according to given parameters (Residents: #62, #64, #70, #73) and failed to administer the ordered insulin (Resident: #64) for 4 of 13 reviewed for diabetes; failed to monitor fluid intake (Resident # 98) for 1 of 1 residents reviewed with fluid intake; failed to monitor heart rate related to blood pressure medication (Residents: #70, #105) for 2 of 13 residents with hypertension; and failed to monitor pre and post heart rate related to nebulizer treatments (Residents: # 3, # 31, # 46, # 64, # 70, # 87, # 98,) for 7 of 7 residents with nebulizer treatments in a sample of 24. Findings include:	F 282	F 282 1. Residents 62, 64, 70, and 73's insulins and sliding scale insulins were clarified for correct insulin and dosage. Resident 98: the physician was notified for clarification of fluid restriction and re-assessed. No negative outcomes were noted. Residents 70 and 105 had their heart rates and blood pressures checked. No negative outcomes were noted. Residents 3, 31, 46, 64, 70, 87, and 98 pre- and post heart rates were checked as related to nebulizers. No negative outcomes were noted.	3/12/11

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F 282	Continued From page 6 1. Resident # 46's clinical record was reviewed on 1/31/11 at 2:55 P.M., and indicated diagnoses of, but not limited to: COPD (chronic obstructive pulmonary disease), intractable epilepsy, seizure disorder, and mild closed head injury. A Physician's Order, dated 1/5/11, indicated, "...Duoneb breathing treatment via nebulizer qid (four times a day). Pre and post assessment to include...# 2. Pulse, Resp (Respirations), # 3. Lung sounds...." Review of the MAR (Medication Administration Record), dated 12/01/10 through 12/31/10, indicated lung sounds were assessed, but it lacked documentation of pre and post pulse assessment for the 121 times the Duoneb had been administered in December. The MAR, dated 1/01/11 through 1/31/11, indicated lung sounds were assessed, but it lacked documentation of pre and post pulse assessment for the 18 times the Duoneb had been administered in January. (Duoneb order was changed to "as needed" on 1/05/11.) 2. Resident # 3's clinical record was reviewed on 2/06/11 at 9:30 A.M. and indicated diagnoses of, but not limited to: chronic obstructive pulmonary disease, depression with psychotic features, and chronic anemia. A Physician's Order, dated 12/01/10, indicated, "...Duoneb breathing treatment via nebulizer qid (four times a day). Pre and post assessment to include...# 2. Pulse, Resp (Respirations), # 3. Lung sounds...." Review of the MAR (Medication Administration	F 282	2. Residents' receiving insulin and sliding scale orders have been checked and clarified with the physician for accuracy. Residents receiving insulin and sliding scale will have all orders and insulins verified by 2 licensed staff prior to administration. New admissions and re-admissions with orders and new orders for insulin will be brought to clinical review, Monday through Friday, and checked for accuracy. Supervisors will double check on evenings and weekends. Residents receiving medications for blood pressure will have heart rates checked and documented per physician orders or pharmacy's recommendation. New orders will be verified by 2 licensed staff and added to the MAR. Residents with fluid restrictions have been placed on the MAR to assure restrictions are maintained. New admissions and re-admissions with orders for fluid restrictions will be verified by 2 licensed staff and then added to the MAR. Residents receiving nebulizer treatments will have pre- and post-pulse, respiration and lung sounds	

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F 282	Continued From page 7 Record), dated 12/01/10 through 12/31/10, indicated lung sounds were assessed, but it lacked documentation of pre and post pulse assessment for the 120 times the Duoneb had been administered in December. 3. The clinical record of Resident # 31 was reviewed on 2/07/11 at 2:00 P.M., and indicated diagnoses of, but not limited to: tracheostomy, seizure disorder, shortness of breath. A Physician's Order, dated 12/02/10, indicated, "...Duoneb breathing treatment via nebulizer qid (four times a day) for 10 days. Pre and post assessment to include...# 2. Pulse, Resp (Respirations), # 3. Lung sounds...." Review of the MAR (Medication Administration Record), dated 12/01/10 through 12/31/10, indicated lung sounds were assessed, but it lacked documentation of pre and post pulse assessment for the 40 times the Duoneb had been administered in December. During interview with RN # 5 on 2/01/11 at 10:20 A.M., she indicated nurse's were not assessing the pulse of residents receiving Duoneb treatments because the MAR did not indicate to take the resident's pulse. She further indicated the facility was going to make the change to the MAR to include a place to record the pulse. Nurse's Notes lacked documentation the resident's pulse had been assessed for the above mentioned dates. 4. The clinical record for Resident # #105 was reviewed on 2/1/11 at 9:00 a.m., and indicated diagnoses of, but not limited to: hypertension (high blood pressure), atrial fibrillation,(irregular heart rate) and hypothyroidism.	F 282	assessed and documented on the MAR per policy. New admissions and re-admissions with orders for nebulizers will be verified by 2 licensed staff and then added to the MAR. 3. Licensed staff will be re-educated on policy and procedures of insulin administration, verifying correct dose and verifying the right insulin. Staff will be re-educated on following fluid restrictions and documentation, monitoring heart rates, and assessing and documenting pulse, and respiration and lung sounds. pre- and post-. with administration of nebulizer treatments. MARs will be monitored daily for 2 weeks, 3x weekly for 2 weeks, and weekly thereafter. Any continued non-compliance will result on 1:1 re-education up to and including termination. 4. Results of audits will be presented to the Executive Director and then forwarded monthly to the Performance Improvement Committee for further recommendations.	

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F 282	Continued From page 8 Review of current physician order, dated 8/28/10, indicated, "Metoprolol tartrate (anti hypertensive medication) 25 milligram (mg) 1/2 tablet orally twice a day (bid)-check apical (ap)-hold med if less than (<) or equal (=) 50 and contact doctor " Review of Medication Administration Record (MAR) for November, December 2010, and January 2011 for apical pulse and indicated the facility failed to follow the physician order related to administration of the Metoprolol tartrate twice a day- check apical pulse. The November, December 2010, and January 2011 indicated the apical pulse had not be documented and or performed. Interview with the South Unit Manager LPN # 1 on 2/1/11 at 10: 00 a.m., indicated the apical pulse should have been obtained prior to the administration of the Metoprolol tartrate and if held, documentation of the reason and contact the doctor. She indicated the apical pulse check had not been performed. 5. The clinical record for Resident # 64, reviewed on 1/31/11 at 9:40 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, chronic kidney disease, chronic obstructive pulmonary disease, chronic bronchitis, hypothyroidism, and hypertension. a.) A (Name) Hospital Patient Information Transfer, dated 6/29/10, indicated, "...Lantus insulin 10 units SQ (subcutaneous, injection) q (every) HS (bedtime)..." Review of the 6/29 through 6/31/10 and 7/01 through 7/31/10 MAR (Medication Administration	F 282		

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F 282	Continued From page 9 Record) lacked documentation that the Lantus insulin was transcribed onto the MAR by the facility, therefore, the patient did not receive the Lantus Insulin as ordered. Doctor (Name) dictation, dated 7/28/10, indicated, "...Lantus insulin was ordered, but it is not being given...." b.) The incorrect type of insulin was administered to Resident # 64 as follows: A "Physician Nursing Home Readmission History and Physical Examination Report," dated 9/29/10, indicated, "She (Resident # 64) is supposed to be on 70/30 (long acting, 24 hours), 55 units in the morning, and 48 units in the evening, but instead, when she got back here there [sic] order was for 70/30 in the morning, but insulin aspart (short acting, 3-5 hours) in the evening, which she has been taking...." A Physician's Order, dated 7/28/10, indicated, "1. Restart Novolog 70/30 55 units SQ (subcutaneous) Q (every) A.M. and 48 units SQ Q P.M....." Review of the July and August, 2010 Medication Administration Records (MARS) indicated, "...Novolog 70/30 55 units SQ Q A.M. and 48 units SQ Q P.M...." The 9/01/10 through 9/30/10 MAR indicated,"...Novolog 70/30 55 units SQ Q A.M. and Novolog (Insulin Aspart) 48 units SQ Q P.M...." Resident # 64's blood glucose readings (Accu Checks) ranged from 64 to 212 at 5:00 A.M. for	F 282		

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F 282	Continued From page 10 9/01/10 through 9/30/10. The 5:00 A.M. Accu Check's were the next available readings after the administration of the Novolog Insulin Aspart. During interview with the LPN # 1 on 2/10/11 at 5:10 P.M., she indicated she was uncertain how the insulin order on the August 2010 MAR was changed from Novolog 70/30 to Novolog Insulin Aspart on the September 2010 MAR. She further indicated the only Physician Order in the clinical record that correlated to the scheduled insulin was for the Novolog 70/30 ordered on 7/28/10. c.) A Physician Order, dated 6/29/10, indicated, "...Insulin (Regular) Sliding Scale as Follows: (Before Meals Only) 0-150=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, > (greater than) 400=call MD (Medical Doctor)..." The July 2010, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results: 7/2 at 2100 (9:00 P.M.), Accu Check result 261. The clinical record indicated the Resident received 6 units. 7/3 at 2100 (9:00 P.M.), Accu Check result 242. The clinical record indicated the Resident received 4 units. 7/4 at 2100 (9:00 P.M.), Accu Check result 350. The clinical record indicated the Resident received 8 units. 7/5 at 2100 (9:00 P.M.), Accu Check result 332. The clinical record indicated the Resident received 8 units. 7/7 at 2100 (9:00 P.M.), Accu Check result 320. The clinical record indicated the Resident received 8 units.	F 282		

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F 282	Continued From page 11 7/8 at 2100 (9:00 P.M.), Accu Check result 260. The clinical record indicated the Resident received 4 units. 7/9 at 2100 (9:00 P.M.), Accu Check result 295. The clinical record indicated the Resident received 6 units. 7/10 at 2100 (9:00 P.M.), Accu Check result 194. The clinical record indicated the Resident received 2 units. 7/12 at 2100 (9:00 P.M.), Accu Check result 336. The clinical record indicated the Resident received 8 units. 7/13 at 2100 (9:00 P.M.), Accu Check result 324. The clinical record indicated the Resident received 8 units. 7/14 at 2100 (9:00 P.M.), Accu Check result 303. The clinical record indicated the Resident received 8 units. 7/15 at 2100 (9:00 P.M.), Accu Check result 357. The clinical record indicated the Resident received 10 units. 7/17 at 2100 (9:00 P.M.), Accu Check result 297. The clinical record indicated the Resident received 6 units. 7/18 at 2100 (9:00 P.M.), Accu Check result 276. The clinical record indicated the Resident received 6 units. 7/21 at 2100 (9:00 P.M.), Accu Check result 313. The clinical record indicated the Resident received 8 units. 7/22 at 2100 (9:00 P.M.), Accu Check result 253. The clinical record indicated the Resident received 6 units. The above mentioned Accu Check's indicated a total of 16 occasions in July 2010, in which the Resident should not have received insulin coverage because the Physician Order specified sliding scale coverage prior to meals only.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING _____ B. WING _____	02/10/2011

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F 282	Continued From page 12 A Physician Note titled "Nursing Home Visit", dated 7/28/10, indicated, "...I reviewed her diabetic orders and currently she is receiving only sliding scale insulin. She was hospitalized at (Name) in June and upon return, 70/30 insulin was not ordered. Lantus insulin was ordered, but is not being given. Her sliding scale currently is not positively affecting her blood sugars...." A Physician Order, dated 9/23/10, clarified 10/27/10, indicated, "...Insulin (Regular) Sliding Scale as Follows: 151-190=5 units, 191-230=8 units, 231-270=11 units, 271-310=14 units, 311-350=17 units, 351-390=20 units, Call MD (Medical Doctor) if > (greater than) 390... Review of the November 2010, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results: 11/16 at 1600 (4:00 P.M.), Accu Check result 152. The clinical record lacked documentation of any insulin given, but the Resident should have received 5 units. A Physician Order, dated 12/1/10, indicated, "...Insulin Sliding Scale as Follows: 1-150=0 units, 151-190=5 units, 191-230=8 units, 231-270=11 units, 271-310=14 units, 311-350=17 units, 351-390=20 units, Call MD (Medical Doctor) if > (greater than) 390... Review of the December 2010, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results:	F 282		

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F 282	Continued From page 13 12/29 at 2100 (9:00 P.M.), Accu Check result 194. The clinical record indicated the Resident received 5 units but the Resident should have received 8 units. Review of the January 2011, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results: 1/17 at 0500 (5:00 A.M.), Accu Check result 186. The clinical record lacked documentation of any insulin given but the Resident should have received 5 units. 1/31 at 0500 (5:00 A.M.) The clinical record lacked documentation of Accu Check monitoring. d.) A Physician Order, dated 9/23/10, indicated, "...Duoneb breathing treatment via nebulizer QID (four times daily). Pre and post assessment to include... # 2 pulse, respirations, # 3 lung sounds...record # of minutes per treatment...." Review of the September 24 through 30, 2010, MAR (Medication Administration Record), for 27 of 27 treatments, lacked documentation of any pre or post assessment related to the Duoneb treatment. The October 2010, MAR, for 116 of 116 treatments, November 2010, MAR, for 110 of 110 treatments, December 2010, MAR, for 121 of 121 treatments, and January 1 through 20, 2011, MAR, for 73 of 73 treatments, lacked documentation of any pre or post treatment pulse. The DON (Director of Nursing), indicated in an interview on 2/4/11 at 11:00 A.M., there was no documentation to support that a pre and post pulse had been taken related to the Duoneb	F 282		

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F 282	Continued From page 14 treatments. 6. The clinical record for Resident # 70, reviewed on 1/31/11 at 10:45 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypothyroidism, bronchitis, congestive heart failure, and hypertension. a.) A Physician Order, dated 12/6/10, indicated, "...AccuCheck QID (four times daily) - before meals and HS (at bedtime)..." Review of the December 6 through 11, 2010, Diabetic Monitoring Flow Sheet and Nurses Notes lacked documentation of Accu Check monitoring. The December 12 through 17, 2010, Diabetic Monitoring Flow Sheet indicated incorrect monitoring as evidence by twice daily Accu Check monitoring instead of four times daily as ordered. Interview with LPN #1 on 2/1/11 at 10:30 A.M., indicated Accu Check documentation is found on the Diabetic Monitoring Flow Sheet. A Physician Order, dated 12/6/10, indicated, "...Insulin (Humalog) Sliding Scale as follows: 110-125=1 units, 126-140=2 units, 141-160=3 units, 161-180=4 units, 181-200=5 units, 201-240=6 units, 241-280=7 units, 281-320=8 units, 321-360=9 units, 361 and > (greater than) =10 units..." Review of the December 12 through 31, 2010, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results: 12/12 at 0500 (5:00 A.M.), Accu Check result 203. The clinical record indicated the Resident	F 282		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	Continued From page 15 did not receive any insulin coverage but should have received 6 units. 12/12 at 1630 (4:30 P.M.), Accu Check result 327. The clinical record indicated the Resident did not receive any insulin coverage but should have received 9 units. 12/13 at 0500 (5:00 A.M.), Accu Check result 156. The clinical record indicated the Resident did not receive any insulin coverage but should have received 3 units. 12/13 at 1630 (4:30 P.M.), Accu Check result 272. The clinical record indicated the Resident did not receive any insulin coverage but should have received 7 units. 12/14 at 0500 (5:00 A.M.), Accu Check result 192. The clinical record indicated the Resident did not receive any insulin coverage but should have received 5 units. 12/14 at 1630 (4:30 P.M.), Accu Check result 306. The clinical record indicated the Resident did not receive any insulin coverage but should have received 8 units. 12/15 at 1630 (4:30 P.M.) The clinical record lacked documentation of Accu Check monitoring. 12/16 at 0500 (5:00 A.M.) and 1630 (4:30 P.M.) The clinical record lacked documentation of Accu Check monitoring. 12/30 at 1600 (4:00 P.M.) The clinical record lacked documentation of Accu Check monitoring. The clinical record indicates a total of 10 occasions in December 2010, that the Resident received incorrect monitoring/coverage. Review of the January 2011, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results:	F 282		

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F 282	Continued From page 16 1/7 at 2100 (9:00 P.M.), Accu Check result 274. The clinical record indicated the Resident received 1 unit but should have received 7 units. 1/10 at 1100 (11:00 A.M.) The clinical record lacked documentation of Accu Check monitoring. 1/11 at 0500 (5:00 A.M.), Accu Check result 143. The clinical record indicated the Resident received 0 units but should have received 3 units. 1/17 at 0500 (5:00 A.M.) and 1600 (4:00 P.M.) The clinical record lacked documentation of Accu Check monitoring. 1/19 at 1600 (4:00 P.M.), Accu Check result 288. The clinical record indicated the Resident received 7 units but should have received 8 units. 1/21 at 0500 (5:00 A.M.), Accu Check result 111. The clinical record indicated the Resident received 0 units but should have received 1 unit. 1/31 at 1600 (4:00 P.M.) The clinical record lacked documentation of Accu Check monitoring. The clinical record indicates a total of 7 occasions in January 2011, that the Resident received incorrect monitoring/coverage. b.) A Physician Order, dated 12/10/10, indicated, "...Duoneb breathing treatment via nebulizer QID (four times daily). Pre and post assessment to include... # 2 pulse, respirations, # 3 lung sounds...record # of minutes per treatment...." Review of the December 10 through 31, 2010, MAR (Medication Administration Record), for 80 of 80 treatments, lacked documentation of any pre or post assessment related to the Duoneb treatment. The January 2011, MAR, for 117 of 117 treatments, lacked documentation of any pre or post treatment pulse.	F 282		

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F 282	Continued From page 17 Interview with LPN #1 on 2/1/11 at 10:30 A.M., indicated all nebulizer treatments are documented on the MAR. c.) A Physician Order, dated 12/6/10, indicated, "...Carvedilol 3.125 mg (milligrams) 1 tab po (orally) BID (twice daily)-Hold if systolic blood pressure < (less than) 100 OR HR (heart rate) < 60..." Review of the December 24 through 31, 2010, MAR (Medication Administration Record), for 12 doses, lacked documentation of any blood pressure or heart rate readings to evaluate the need for Carvedilol. Review of the January 2011, MAR, for 62 doses, lacked documentation of heart rate readings to evaluate the appropriateness for Carvedilol. During an interview with the DNS (Director of Nursing Services) on 2/4/11 at 11:20 A.M., it was indicated that both the pulse and blood pressure should be evaluated prior to giving Carvedilol. 7. The clinical record for Resident # 87, reviewed on 1/31/11 at 11:35 AM., indicated diagnoses of, but not limited to: obstructive chronic bronchitis, and hypertension. A Physician Order, dated 5/2/10, indicated, "...Duoneb breathing treatment via nebulizer QID (four times daily). Pre and post assessment to include... # 2 pulse, respirations, # 3 lung sounds...record # of minutes per treatment...." The December 2010, MAR (Medication Administration Record), for 110 of 110 treatments	F 282		

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F 282	Continued From page 18 and January 2011, MAR, for 94 of 94 treatments, lacked documentation of any pre or post treatment pulse. Interview with LPN #1 on 2/1/11 at 10:30 A.M., indicated all nebulizer treatments are documented on the MAR. 8. The clinical record for Resident # 98, reviewed on 2/3/11 at 2:40 P.M., indicated diagnoses of, but not limited to: chronic airway obstruction, hypertension, urinary tract infection, and bladder outlet obstruction. a.) A Physician Order, dated 9/18/10, indicated, "...Duoneb breathing treatment via nebulizer QID (four times daily). Pre and post assessment to include... # 2 pulse, respirations, # 3 lung sounds...record # of minutes per treatment...." The December 2010, MAR (Medication Administration Record), for 107 of 107 treatments and January 2011, MAR, for 78 of 78 treatments, lacked documentation of any pre or post treatment pulse. b.) A Physician Order, dated 9/29/10, indicated, "...Pulmicort breathing treatment via nebulizer QD (once daily). Pre and post assessment to include # (1) LOC (level of consciousness), # 2 pulse, respirations, # 3 lung sounds...record # of minutes per treatment...." Review of the December 2010, MAR, for 30 of 30 treatments and January 2011, MAR, for 30 of 30 treatments, lacked documentation of any pre or post assessment related to the Pulmicort treatment.	F 282		

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F 282	Continued From page 19 During an interview on 2/1/11 at 10:15 A.M., LPN #1 indicated standard practice for breathing treatments via nebulizer would be to take both pulse and respirations. c.) A Physician Order, dated 9/29/10, indicated, "...2 liters/day fluid restriction..." Review of the Care Plan, dated 9/28/10, indicated "...1800 cc (milliliters) fluid restriction...2000 cc..." The December 2010, MAR (Medication Administration Record), indicated implementation of this order per nursing signatures on days 1 through 31 for both the 6 P (p.m.) - 6 A (a.m.) and 6 A - 6 P shift, however, the December Comprehensive Intake - Output Record is unavailable for review. During an interview with DNS on 2/4/11 at 11:00 a.m., it was indicated that intake is not documented anywhere related to fluid restriction. Interview with LPN # 1 on 2/9/11 at 2:00 p.m., indicated the December Comprehensive Intake - Output Record was unavailable. Review of the January 2011, MAR, indicated implementation of this order per nursing signatures on days 1 through 31 for 58 shifts out of 62. The January Comprehensive Intake - Output Record lacked documentation of Resident intake on the following days: 1/1 through 1/17, The Clinical Record lacked intake documentation for both shifts for a total of 34 occasions.	F 282		

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F 282	Continued From page 20 1/18, The Clinical Record lacked intake documentation for one shift. 1/19, The Clinical Record lacked intake documentation for both shifts. 1/20, The Clinical Record lacked intake documentation for one shift. 1/21 through 1/31, The Clinical Record lacked intake documentation for both shifts for a total of 22 occasions. A total of 60 occasions for January 2011, lacked documentation of intake. 9. The clinical record for Resident # 62, reviewed on 2/4/11 at 2:20 P.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and Alzheimer's disease. A Physician Order, dated 1/27/10, indicated "...Insulin (Humalog) Sliding Scale daily based on sliding scale results. 170-200=3 units, 201-250=4 units, 251-300=5 units, 301-350=6 units, 351-400=7 units..." Review of the November 2010, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results: 11/1 at 0500 (5:00 A.M.), Accu Check result 185. The clinical record lacked documentation of any insulin coverage but the Resident should have received 3 units. 11/14 at 2100 (9:00 P.M.), Accu Check result 464. The Resident received 7 units. This result is outside of the sliding scale parameters but the clinical record lacked documentation that the nurse contacted the physician for clarification on the amount of insulin coverage to give.	F 282		

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F 282	Continued From page 21 11/21 at 2100 (9:00 P.M.), Accu Check result 458. The Resident received 7 units. This result is outside of the sliding scale parameters but the clinical record lacked documentation that the nurse contacted the physician for clarification on the amount of insulin coverage to give. 11/28 at 2100 (9:00 P.M.) The clinical record lacked documentation of Accu Check monitoring. The clinical record indicates a total of 4 occasions in November 2010, that the Resident received incorrect monitoring/coverage. Review of the December 2010, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results: 12/10 at 2100 (9:00 P.M.), Accu Check result 389. The clinical record lacked documentation of any insulin given but the Resident should have received 7 units. Review of the January 2011, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results: 1/1 at 2100 (9:00 P.M.), Accu Check result 181. The clinical record lacked documentation of any insulin given but the Resident should have received 3 units. 1/12 at 2100 (9:00 P.M.), Accu Check result 291. The clinical record indicated the Resident received 4 units but should have received 5 units. 1/17 at 2100 (9:00 P.M.), Accu Check result 194. The clinical record lacked documentation of any insulin given but the Resident should have received 3 units. 1/17 at 2100 (9:00 P.M.), Accu Check result 437.	F 282		

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F 282	Continued From page 22 The clinical record indicated the Resident received 7 units. This result is outside of the sliding scale parameters but the clinical record lacked documentation that the nurse contacted the physician for clarification on the amount of insulin coverage to give. 1/24 at 1100 (11:00 A.M.), Accu Check result 414. The clinical record indicated the Resident received 7 units. This result is outside of the sliding scale parameters but the clinical record lacked documentation that the nurse contacted the physician for clarification on the amount of insulin coverage to give. The clinical record indicates a total of 5 occasions in January 2011, that the Resident received incorrect monitoring/coverage. 10. The clinical record for Resident # 73, reviewed on 2/4/11 at 3:00 P.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and congestive heart failure. A Physician Order, dated 8/14/08, indicated "...Humulin 70/30...40 units liquid subcutaneous (injection) q (every) a.m. - Hold if a.m. Accu Check is < (less than) 100..." Interview with LPN #1 on 2/1/11 at 10:30 A.M., indicated Accu Check documentation is found on the Diabetic Monitoring Flow Sheet. Review of the November 2010, MAR (Medication Administration Record)indicated insulin was incorrectly administered to the Resident for the following Accu Check results: 11/7 Accu Check result at 0500 (5:00 A.M.), 50. The clinical record indicated OJ (orange juice)	F 282		

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F 282	Continued From page 23 was given. Accu Check result post OJ was 78. The clinical record indicated 40 units of insulin was given at 0730 (7:30 A.M.) but this should have been held because the a.m. Accu Check was less than 100. The clinical record indicated the 1100 (11:00 A.M.) Accu Check was 262. 11/15 Accu Check result at 0500 (5:00 A.M.), 81. The clinical record indicated 40 units of insulin was given at 0730 (7:30 A.M.) but this should have been held because the A.M. Accu Check was less than 100. The clinical record indicated the 1100 (11:00 A.M.) Accu Check was 153. 11/26 Accu Check result at 0500 (5:00 A.M.), 70. The clinical record indicated 40 units of insulin was given at 0730 (7:30 A.M.) but this should have been held because the a.m. Accu Check was less than 100. The clinical record indicated the 1100 (11:00 A.M.) Accu Check was 243. A Physician Order, dated 3/02/08, indicated "...Humulin 70/30...10 units liquid subcutaneous (injection) q (every) p.m. - Hold if p.m. Accu Check is 100 or below..." 11/24 Accu Check result at 1600 (4:00 P.M.), 70. The clinical record indicated 10 units of insulin was given at 1630 (4:30 P.M.) but this should have been held because the P.M. Accu Check was 100 or less. The clinical record indicated the 2100 (9:00 P.M.) Accu Check was 237. 11/26 Accu Check result at 1600 (4:00 P.M.), 91. The clinical record indicated 10 units of insulin was given at 1630 (4:30 P.M.) but this should have been held because the P.M. Accu Check was 100 or less. The clinical record indicated the 2100 (9:00 P.M.) Accu Check was 366.	F 282		

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F 282	Continued From page 24 The clinical record indicates a total of 5 occasions in November 2010, that the Resident received incorrect coverage. A Physician Order, dated 6/2/08, indicated "...Insulin (Humulin) sliding scale as follows: 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=10 units, 351-400=16 units, 401-500=20 unit, > (greater than) 500=25 units and call MD (medical doctor)..." Review of the November 2010, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results: 11/3 at 1100 (11:00 A.M.), Accu Check result 201. The clinical record indicated the Resident received 2 units but the Resident should have received 4 units. 11/27 at 1600 (4:00 P.M.), Accu Check result 125. The clinical record indicated the Resident received 10 units but should not have received any insulin coverage. Review of the December 2010, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results: 12/25 at 1600 (4:00 P.M.), Accu Check result 248. The clinical record indicated the Resident received 6 units but should have received 4 units. A Physician Order, dated 12/29/10, indicated "...Insulin (Novolog) sliding scale as follows: 160=1 unit, 180=2 units, 200=3 units, 220=4	F 282		

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	155219	A. BUILDING _____ B. WING _____	02/10/2011

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F 282	Continued From page 25 units, 240=5 units, 260=6 units, 280=7 units, 300=8 units, 320=9 units, 340=10 units, 360=11 units, 380=12 units, 400=13 units, 420=14 units, 440=15 units, 460=16 units, 480=17 units, 500=18 units..." Review of the December 2010, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results: 12/31 at 2100 (9:00 P.M.), Accu Check result 124. The clinical record indicated the Resident received 2 units but should not have received any insulin coverage. Review of the January 2011, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results: 1/3 at 1600 (4:00 P.M.), Accu Check result 190. The clinical record indicated the Resident received 3 units but should have received 2 units. 1/4 at 1600 (4:00 P.M.), Accu Check result 179. The clinical record indicated the Resident received 2 units but should have received 1 unit. 1/5 at 1100 (11:00 A.M.), Accu Check result 354. The clinical record indicated the Resident received 11 units but should have received 10 units. 1/7 at 1600 (4:00 P.M.), Accu Check result 195. The clinical record indicated the Resident received 3 units but should have received 2 units. 1/14 at 2100 (9:00 P.M.) The clinical record lacked documentation of Accu Check monitoring. 1/17 at 0500 (5:00 A.M.) The clinical record lacked documentation of Accu Check monitoring. 1/17 at 1100 (11:00 A.M.), Accu Check result 402. The clinical record indicated the Resident	F 282		

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F 282	Continued From page 26 received 16 units but should have received 13 units. 1/18 at 1600 (4:00 P.M.), Accu Check result 235. The clinical record indicated the Resident received 5 units but should have received 4 units. 1/24 at 1100 (11:00 A.M.), Accu Check result 352. The clinical record indicated the Resident received 5 units but should have received 10 units. 1/25 at 0500 (5:00 A.M.) The clinical record lacked documentation of Accu Check monitoring. 1/26 at 1600 (4:00 P.M.), Accu Check result 161. The clinical record indicated the Resident received 2 units but should have received 1 unit. 1/27 at 1100 (11:00 A.M.), Accu Check result 270. The clinical record indicated the Resident received 7 units but should have received 6 units. 1/28 at 1600 (4:00 P.M.), Accu Check result 152. The clinical record indicated the Resident received 1 unit but should not have received any insulin coverage. 1/29 at 1100 (11:00 A.M.), Accu Check result 158. The clinical record indicated the Resident received 1 unit but should not have received any insulin coverage. The clinical record indicates a total of 14 occasions in January 2011, that the Resident received the incorrect coverage. A physician order dated 12/23/10, indicated "...Lantus...20 units injection...q (every) hs (bedtime)..." Review of the January 2011, MAR (Medication Administration Record) lacked documentation of insulin coverage on the following dates: 1/6 at 1930 (7:30 P.M.). The clinical record	F 282		

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F 282	Continued From page 27 lacked documentation of the scheduled insulin dose being given. 1/7 at 1930 (7:30 P.M.). The clinical record lacked documentation of the scheduled insulin dose being given. 1/10 at 1930 (7:30 P.M.). The clinical record lacked documentation of the scheduled insulin dose being given. The clinical record indicates a total of 3 occasions in January 2011, that the Resident did not receive scheduled insulin coverage. A facility policy titled "Blood Sugar Monitoring," revised 10/31/10, received 2/2/11 at 12:05 P.M., indicated, "...Procedure...25. Consult with physician regarding insulin order and frequency of monitoring blood sugar to confirm effectiveness of sliding scale insulin coverage in lowering blood sugar to an acceptable range. 31. Record the results in the patient's medical record (e.g., chart, MAR,...)..." A facility policy titled "Nebulizer Therapy", revised 10/31/10, received 2/2/11 at 12:05 P.M., indicated, "...Procedure... 22. Assess therapy for efficacy by:... c. Periodic monitoring the patient for adverse reactions such as tachycardia.... d. Periodic evaluation of breath sounds before and after therapy...." A facility policy titled "Blood Pressure Measurement", revised 10/31/10, received 2/2/11 at 12:05 P.M., "...Procedure... 17. Record the blood pressure in the patient's medical record. 18. If blood pressure out of range, notify physician and follow orders, if applicable...."	F 282		

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F 282	Continued From page 28 A facility policy titled "Fluid Restriction," revised 10/31/08, indicated, "...Procedure...8. Place resident on Intake and Output (I&O) and monitor fluid intake...Documentation Guidelines...5. Document...on designated form resident's fluid intake...."	F 282		
F 284 SS=D	3.1-35(g)(2) 483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide written discharge instructions for residents and/or caretakers in a language and manner they understood for 3 of 3 residents discharged to home in the sample of 24. Residents: #120, #121, #122 Finding include:: The closed record of Resident #120 was reviewed on 2/3/11 at 10:00 a.m., and indicated diagnoses to include but not limited to include dementia, depression, convulsion, and brain injury. The record indicated Resident #120 was discharged to home on 1/14/11 without providing	F 284	F 284 1. Residents 120, 121, and 122 no longer reside at the facility. 2. Residents being discharged from the facility will receive discharge instructions in lay language and be given the opportunity to ask for clarification if needed. 3. Licensed staff will be re-educated on appropriate discharge instructions per policy. Discharge instructions will be audited/reviewed by Unit Managers, or their designees, prior to discharge. Any continued non-compliance will result in 1:1 re-education up to and including termination.	3/12/11

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F 284	Continued From page 29 discharge instructions in lay language so the resident or caretaker could understand all areas addressed as applicable upon discharge to home. Resident discharge information was written on a "Physician Progress Notes" and there were no resident, care taker or the nurse's signature to indicate this information had been given to the resident and or caretaker. The information of the resident's medication was not in lay language, but as follows: 1. For the word "every" wrote a "q" 2. For the route wrote "P.O." instead by mouth or orally 3. The dosage of medication was written "mg" not milligrams, 4. The resident was on hypertension medication and it was written "hold if systolic BP <120" not written, "hold medication if systolic blood pressure greater than 120." 5. The "multivitamins with iron every morning" it was written, "multivitamins with fe so4 q a.m.". 6. The frequency of "two times a day" but written "2 x day." 7. The frequency of "three times a day" but written " 3 x day." 2. Review of Resident #121's closed record on 2/4/11 at 10:00 a.m., indicated diagnoses to include but not limited to include diabetes, morbid obesity, osteoarthrosis, and manic depressive. The record indicated Resident #121 was discharged to home on 12/13/10 without providing discharge instruction in lay language so the resident or caretaker could understand all areas addressed as applicable upon discharge to home. Resident discharge information was written on a	F 284	4. Audits will be presented to the Executive Director for review and will then be forwarded monthly to the Performance Improvement Committee to determine if further educational is needed.	

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F 284	Continued From page 30 "Physician Progress Notes" and there were no resident, care taker or the nurse's signature to indicate this information had been given to the resident and or caretaker. The information of the resident's medication was not in lay language but as follows: 1. For the word "every" wrote a "q" 2. For the route wrote "P.O." instead by mouth or orally 3. The dosage of medication was written "mg" not milligrams, 4. The word one, two, and three was written in Roman numerals 3. Review of Resident #122's closed record on 2/4/11 at 11:00 a.m., indicated diagnoses to include but not limited to include diabetes, hypertension, atrial fibrillation, chronic anticoagulant,renal failure, anorexia, obesity, depressive disorder, and cholecystitis. The record indicated Resident #122 was discharged to home on 11/22/10 without providing discharged instruction in lay language so the resident or caretaker could understand all areas addressed as applicable upon discharge to home. In addition, the print discharge instructions lacked documentation of the resident, care takers, and nurse's signature. Resident discharge information was written on typing paper and there were no signatures of resident, care taker or the nurses to indicate this information had been given to the resident and or caretaker. The information of the resident medication was not in lay language, but as follows: 1. The route of medication was not addressed 2. The dosage of medication was written "mg" not	F 284		

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F 284	Continued From page 31 milligrams, 3. The pain pill frequency was written "prn" and "not as needed" every six hours. During interview with the Director of Nursing (DON) on 2/7/11 at 9:00 a.m., indicated the facility staff did not follow the discharge instruction policy and the facility did not use the discharge instructions form and lacked resident and or responsible party signatures as well as a nurse's signature. Review of the policy and procedure titled "Discharge Instructions," dated 1/9/06, indicated, "1. complete the form in lay language so the resident and caretaker can understand all areas addressed as applicable upon discharge....". In addition, the form had a place for resident and caretaker signature and nurse signature."	F 284		
F 309 SS=D	3.1-36(a)(3) 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed provide care and services related to the management of diabetes; in that insulin was not administered according to physician ordered	F 309	F 309 1. Residents 64, 70, and 73's insulin and sliding scale were verified with the physician for clarification and accuracy, and for correct insulin and dosage. 2. Residents receiving insulin and sliding scale: all orders for insulin and amounts will be verified by 2 licensed staff prior to administration. New orders, new admissions, and re-admissions with insulin orders	3/12/11

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F 309	Continued From page 32 parameters (Residents: #64, #70, #73) and routine insulin was not administered as ordered Resident: #64) for 3 of 13 residents reviewed for diabetes in a sample of 24. Findings include: 1. The clinical record for Resident # 64, reviewed on 1/31/11 at 9:40 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, chronic kidney disease, hypothyroidism, and hypertension. a.) A (Name) Hospital Patient Information Transfer, dated 6/29/10, indicated, "...Lantus insulin 10 units SQ (subcutaneous, injection) q (every) HS (bedtime)...." Review of the 6/29 through 6/31/10 and 7/01 through 7/31/10 MAR (Medication Administration Record) lacked documentation that the Lantus insulin was transcribed onto the MAR by the facility, therefore, the patient did not receive the Lantus Insulin as ordered for 34 days. A Physician's Note titled, "Nursing Home Visit," dated 7/28/10, indicated, "...I reviewed her Accu Check over the past month and they are running anywhere from 250 to 400. I reviewed her diabetic orders and currently she is receiving only sliding scale insulin. She was hospitalized at (Name) in June and upon return, 70/30 insulin was not ordered. Lantus insulin was ordered, but it is not being given. Her sliding scale currently is not positively affecting her blood sugars...." Interview with DON (Director of Nursing), on 2/7/11 at 7:00 P.M., indicated that it was hard to determine exactly what happened because most	F 309	will be checked and verified by 2 licensed nurses and then added to the MAR. 3. Licensed staff will be re-educated on following physician orders, transcribing medications, and placing on the MAR and Diabetic Flow Sheet. Diabetic Flow Sheets and MARS will be audited daily for 2 weeks, 3x weekly for 2 weeks, and then weekly thereafter. Any non-compliance will result in 1:1 re-education up to and including termination. 4. Audits will be presented to the Executive Director for review and will then be presented monthly to the Performance Improvement Committee for further recommendations.	

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F 309	Continued From page 33 of that staff is no longer employed by the facility and it was prior to her employment with the facility. b.) The incorrect type of insulin was administered to Resident # 64 as follows: A "Physician Nursing Home Readmission History and Physical Examination Report," dated 9/29/10, indicated, "She (Resident # 64) is supposed to be on 70/30 (long acting, 24 hours), 55 units in the morning, and 48 units in the evening, but instead, when she got back here there [sic]order was for 70/30 in the morning, but insulin aspart (short acting, 3-5 hours) in the evening, which she has been taking...." A Physician's Order, dated 7/28/10, indicated, "1. Restart Novolog 70/30 55 units SQ (subcutaneous) Q (every) A.M. and 48 units SQ Q P.M....." Review of the July and August, 2010 Medication Administration Records (MARS) indicated, "Novolog 70/30 55 units SQ Q A.M. and 48 units SQ Q P.M....." The 9/01/10 through 9/30/10 MAR indicated,"Novolog 70/30 55 units SQ Q A.M. and Novolog (Insulin Aspart) 48 units SQ Q P.M. Resident # 64's blood glucose readings (Accu Checks) ranged from 64 to 212 at 5:00 A.M. for 9/01/10 through 9/18/10 and 9/23/10 through 9/30/10. The 5:00 A.M. Accu Check's were the next available readings after the administration of the Novolog Insulin Aspart. During interview with LPN # 1 on 2/10/11 at 5:10	F 309		

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F 309	Continued From page 34 P.M., she indicated she was uncertain how the insulin order on the August 2010 MAR was changed from Novolog 70/30 to Novolog Insulin Aspart on the September 2010 MAR. She further indicated the only Physician Order in the clinical record that correlated to the scheduled insulin was for the Novolog 70/30 ordered on 7/28/10. c.) A Physician Order, dated 6/29/10, indicated, "...Insulin (Regular) Sliding Scale as Follows: (Before Meals Only) 0-150=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, > (greater than) 400=call MD (Medical Doctor)..." The July 2010, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage a total of 16 occasions in July 2010, in which the resident should not have received insulin coverage because the Physician Order specified sliding scale coverage prior to meals only. 7/2 at 2100 (9:00 P.M.), Accu Check result 261. The clinical record indicated the Resident received 6 units. 7/3 at 2100 (9:00 P.M.), Accu Check result 242. The clinical record indicated the Resident received 4 units. 7/4 at 2100 (9:00 P.M.), Accu Check result 350. The clinical record indicated the Resident received 8 units. 7/5 at 2100 (9:00 P.M.), Accu Check result 332. The clinical record indicated the Resident received 8 units. 7/7 at 2100 (9:00 P.M.), Accu Check result 320. The clinical record indicated the Resident received 8 units. 7/8 at 2100 (9:00 P.M.), Accu Check result 260. The clinical record indicated the Resident	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 35 received 4 units. 7/9 at 2100 (9:00 P.M.), Accu Check result 295. The clinical record indicated the Resident received 6 units. 7/10 at 2100 (9:00 P.M.), Accu Check result 194. The clinical record indicated the Resident received 2 units. 7/12 at 2100 (9:00 P.M.), Accu Check result 336. The clinical record indicated the Resident received 8 units. 7/13 at 2100 (9:00 P.M.), Accu Check result 324. The clinical record indicated the Resident received 8 units. 7/14 at 2100 (9:00 P.M.), Accu Check result 303. The clinical record indicated the Resident received 8 units. 7/15 at 2100 (9:00 P.M.), Accu Check result 357. The clinical record indicated the Resident received 10 units. 7/17 at 2100 (9:00 P.M.), Accu Check result 297. The clinical record indicated the Resident received 6 units. 7/18 at 2100 (9:00 P.M.), Accu Check result 276. The clinical record indicated the Resident received 6 units. 7/21 at 2100 (9:00 P.M.), Accu Check result 313. The clinical record indicated the Resident received 8 units. 7/22 at 2100 (9:00 P.M.), Accu Check result 253. The clinical record indicated the Resident received 6 units. A "Physician Progress Note", dated 8/4/10, indicated "...I noticed that her Accu Checks were running way out of control, and figured out her 70/30 insulin was not being given. It was restarted last week. I looked at her Accu Check readings today, and they are much better, now running from 90-150...."	F 309		

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F 309	Continued From page 36 Interview with DON (Director of Nursing), on 2/7/11 at 7:00 P.M., indicated that it was hard to determine exactly what happened because most of that staff is no longer employed by the facility and it was prior to her employment with the facility. A Physician Order, dated 9/23/10, clarified 10/27/10, indicated, "...Insulin (Regular) Sliding Scale as Follows: 151-190=5 units, 191-230=8 units, 231-270=11 units, 271-310=14 units, 311-350=17 units, 351-390=20 units, Call MD (Medical Doctor) if > (greater than) 390... Review of the November 2010, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results: 11/16 at 1600 (4:00 P.M.), Accu Check result 152. The clinical record lacked documentation of any insulin given but the Resident should have received 5 units. A Physician Order, dated 12/1/10, indicated, "...Insulin Sliding Scale as Follows: 1-150=0 units, 151-190=5 units, 191-230=8 units, 231-270=11 units, 271-310=14 units, 311-350=17 units, 351-390=20 units, Call MD (Medical Doctor) if > (greater than) 390... Review of the December 2010, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results: 12/29 at 2100 (9:00 P.M.), Accu Check result 194. The clinical record indicated the Resident	F 309		

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F 309	Continued From page 37 received 5 units but the Resident should have received 8 units. Review of the January 2011, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results: 1/17 at 0500 (5:00 A.M.), Accu Check result 186. The clinical record lacked documentation of any insulin given but the Resident should have received 5 units. 1/31 at 0500 (5:00 A.M.) The clinical record lacked documentation of Accu Check monitoring. 2. The clinical record for Resident # 70, reviewed on 1/31/11 at 10:45 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypothyroidism, and hypertension. A Physician Order, dated 12/6/10, indicated, "...AccuCheck QID (four times daily) - before meals and HS (at bedtime)..." Review of the December 6 through 11, 2010, Diabetic Monitoring Flow Sheet lacked documentation of Accu Check monitoring. The December 12 through 17, 2010, Diabetic Monitoring Flow Sheet indicated incorrect monitoring as evidence by twice daily Accu Check monitoring instead of four times daily as ordered A Physician Order, dated 12/6/10, indicated, "...Insulin (Humalog) Sliding Scale as follows: 110-125=1 units, 126-140=2 units, 141-160=3 units, 161-180=4 units, 181-200=5 units, 201-240=6 units, 241-280=7 units, 281-320=8 units, 321-360=9 units, 361 and > (greater than) =10 units..."	F 309		

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F 309	Continued From page 38 Review of the December 12 through 31, 2010, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results: 12/12 at 0500 (5:00 A.M.), Accu Check result 203. The clinical record indicated the Resident did not receive any insulin coverage but should have received 6 units. This resulted in her blood sugar increasing to 327 at the 4:30 P.M. Accu Check at which time she should have received 9 units. 12/13 at 0500 (5:00 A.M.), Accu Check result 156. The clinical record indicated the Resident did not receive any insulin coverage but should have received 3 units. This resulted in her blood sugar increasing to 272 at the 4:30 P.M. Accu Check at which time she should have received 7 units. 12/14 at 0500 (5:00 A.M.), Accu Check result 192. The clinical record indicated the Resident did not receive any insulin coverage but should have received 5 units. This resulted in her blood sugar increasing to 306 at the 4:30 P.M. Accu Check at which time she should have received 8 units. 12/15 at 1630 (4:30 P.M.) The clinical record lacked documentation of Accu Check monitoring. 12/16 at 0500 (5:00 A.M.) and 1630 (4:30 P.M.) The clinical record lacked documentation of Accu Check monitoring. 12/30 at 1600 (4:00 P.M.) The clinical record lacked documentation of Accu Check monitoring.	F 309		

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F 309	Continued From page 39 The clinical record indicates a total of 10 occasions in December 2010, that the Resident received incorrect monitoring/coverage. Review of the January 2011, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results: 1/7 at 2100 (9:00 P.M.), Accu Check result 274. The clinical record indicated the Resident received 1 unit but should have received 7 units. 1/10 at 1100 (11:00 A.M.) The clinical record lacked documentation of Accu Check monitoring. 1/11 at 0500 (5:00 A.M.), Accu Check result 143. The clinical record indicated the Resident received 0 units but should have received 3 units. 1/17 at 0500 (5:00 A.M.) and 1600 (4:00 P.M.) The clinical record lacked documentation of Accu Check monitoring. 1/19 at 1600 (4:00 P.M.), Accu Check result 288. The clinical record indicated the Resident received 7 units but should have received 8 units. 1/21 at 0500 (5:00 A.M.), Accu Check result 111. The clinical record indicated the Resident received 0 units but should have received 1 unit. 1/31 at 1600 (4:00 P.M.) The clinical record lacked documentation of Accu Check monitoring. The clinical record indicated a total of 7 occasions in January 2011, that the Resident received incorrect monitoring/coverage. Review of Nurses Notes for the above mentioned time frame lacked documentation of assessments as to how the lack of insulin coverage affected the Resident. 3. The clinical record for Resident # 73, reviewed	F 309		

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F 309	Continued From page 40 on 2/4/11 at 3:00 P.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and congestive heart failure. A Physician Order, dated 12/29/10, indicated "...Insulin (Novolog) sliding scale as follows: 160=1 unit, 180=2 units, 200=3 units, 220=4 units, 240=5 units, 260=6 units, 280=7 units, 300=8 units, 320=9 units, 340=10 units, 360=11 units, 380=12 units, 400=13 units, 420=14 units, 440=15 units, 460=16 units, 480=17 units, 500=18 units..." Review of the January 2011, Diabetic Monitoring Flow Sheet indicated incorrect sliding scale coverage for the following Accu Check results: 1/14 at 2100 (9:00 P.M.) Lacked documentation of Accu Check monitoring or sliding scale coverage. The next available reading on 1/15 at 0500 (5:00 A.M.) was 254. 1/17 at 0500 (5:00 A.M.), Accu Check result 228. The clinical record lacked documentation that the Resident received sliding scale coverage but should have received 4 units. The next available Accu Check at 1100 (11:00 A.M.), was 402. 1/25 at 0500 (5:00 A.M.), Accu Check result 178. The clinical record lacked documentation that the Resident received sliding scale coverage but should have received 1 units. The next available Accu Check at 1100 (11:00 A.M.), was 240. 1/27 at 1100 (11:00 A.M.), Accu Check result 270. The clinical record indicated the Resident received 7 units but should have received 6 units. The next available Accu Check at 1600 (4:00 P.M.) was 98.	F 309		

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F 309	Continued From page 41 The clinical record indicates a total of 4 occasions in January 2011, that the Resident received the incorrect coverage. A physician order, dated 12/23/10, indicated "...Lantus...20 units injection...q (every) hs (bedtime)..." Review of the January 2011, MAR (Medication Administration Record) lacked documentation of insulin coverage on the following dates: 1/6 at 1930 (7:30 P.M.). The clinical record lacked documentation of the scheduled insulin dose being given. 1/7 at 1930 (7:30 P.M.). The clinical record lacked documentation of the scheduled insulin dose being given. 1/10 at 1930 (7:30 P.M.). The clinical record lacked documentation of the scheduled insulin dose being given. The clinical record indicates a total of 3 occasions in January 2011, that the Resident did not receive the scheduled insulin coverage. A facility policy titled "Blood Sugar Monitoring," revised on 10/31/10, received 2/2/11 at 12:05 P.M., indicated, "...Procedure...25. Consult with physician regarding insulin order and frequency of monitoring blood sugar to confirm effectiveness of sliding scale insulin coverage in lowering blood sugar to an acceptable range. 31. Record the results in the patient's medical record (e.g., chart, MAR,...)..." Interview with DON (Director of Nursing), on	F 309		

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F 309	Continued From page 42 2/7/11 at 7:00 P.M., indicated that it was hard to determine exactly what happened because most of that staff is no longer employed by the facility and it was prior to her employment with the facility.	F 309		
F 322 SS=D	3.1-37(a) 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure proper medication protocol was followed for administration of medication in a G-tube (gastrostomy tube) for 1 of 2 residents reviewed with G-tubes in a sample of 24. Resident: # 31 Findings include: The clinical record of Resident # 31 was reviewed on 2/07/11 at 2:00 P.M. and indicated diagnoses of, but not limited to: tracheostomy, seizure disorder, shortness of breath. During observation of a medication administration	F 322	F 322 1. Resident #31's gastrostomy tube has been checked for placement using a bolus and residual check. 2. Residents with gastrostomy tubes will have placement checks with a bolus and residual checks per policy. 3. Licensed staff will be re-educated on policy and procedures regarding proper medication protocol for administration of medication in a gastrostomy tube. One licensed staff will be observed during medication administration of G-tube 2x weekly and then weekly thereafter by the Unit Manager or designee. Any non-compliance will result in 1:1 re-education up to and including termination.	3/12/11

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F 322	Continued From page 43 pass on 2/01/11 at 1:00 P.M., LPN # 6 washed her hands, donned gloves, and placed a clean cloth towel on the resident's abdomen. She checked for tube placement using the air bolus method. She then proceeded with a five cc (centimeter) water flush and administered seven medications with a five cc water flush between each medication and after the final medication. She did not check for residual prior to beginning the medication administration and the first water flush. Resident # 31's clinical record indicated he was a continuous feed via the gastrostomy tube from 3:00 P.M. through 9:00 A.M. LPN # 6 indicated in an interview on 2/01/11 at 1:10 P.M., she checked for tube placement and thought she had checked for residual prior to administering the medication. "I was nervous" (about being observed). A facility policy titled "Medication via Feeding Tube," revised 10/31/10, indicated, "Procedure: 5. Wash hands and put on gloves...8. Check feeding tube placement & residual check...."	F 322	4. Audits will be presented to the Executive Director for review and then forwarded monthly to the Performance Improvement Committee for further recommendations.	
F 323 SS=G	3.1-44(a)(2) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	F 323 1. Resident #3 no longer resides at the facility. Resident #31's bed was placed in the low position. 2. Residents at risk for falls: care plans and interventions have been updated to reflect current status. Residents who experience falls: the event reports and charts	3/12/11

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F 323	Continued From page 44 by: Based on observation, interview, and record review, the facility failed to evaluate and analyze causative factors related to falls and develop appropriate interventions to prevent a fall which resulted in a facial laceration, large contusion, transportation to the Emergency Department and three sutures above the right eye (Resident # 3). The facility also failed to ensure the bed height of a seizure resident was in the lowest position to prevent the risk of possible injury (Resident # 31). This deficient practice affected 2 of 12 residents reviewed for falls in a sample of 24. Findings include: 1. During initial tour of the North Unit of the facility on 1/30/11 at 3:30 P.M., while accompanied by RN # 5, Resident # 3 was observed with a large purplish brown bruise to his right eye. Above the right eye were visible sutures to a scabbed laceration. The clinical record of Resident # 3 was reviewed on 2/06/11 at 9:30 A.M. and indicated diagnoses of, but not limited to: chronic anemia, chronic obstructive pulmonary disorder, and depression with psychotic features. Resident # 3 incurred 8 falls between 10/08/10 and 2/05/11. Review of Nurse's Notes indicated the following falls: 10/08/10 at 6:00 P.M.-"Called to room. Resident on floor on R (right) side @ bedside. ROM (range of motion) to all extremities (sic). Assist 2 to B.R. (bathroom) toileted...." 10/08/10 at 6:40 P.M.-"Called to room. Res (resident) on floor bed-side (sic) bed. Legs in front of him. No injury noted...."	F 323	will be reviewed in clinical review (Monday through Friday) to determine if interventions and care plans are updated appropriately. Resident #31's bed will be maintained in the low position except when giving care. 3. Licensed staff will be re-educated on falls, interventions, and care plans – according to policy. Falls and /or interventions will be reviewed in clinical (Monday through Friday) to assure that interventions and dates correlate on the care plan. Any non-compliance will result in 1:1 re-education up to and including termination. 4. Reviews will be brought to the Executive Director for review and forwarded monthly to the Performance Improvement Committee for further recommendations.	

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F 323	Continued From page 45 11/21/10 "late entry for 6:30 P.M.-Resident was observed on his Rt (right) side @ end of bed. Resident states he was 'going to BR (bathroom)...tab alarm not sounded. Resident assisted back to bed. Tab alarm replaced. Resident says 'Don't put that on it makes noise.' Resident put tab alarm back in place to silence alarm...." 12/24/10 at 7:30 A.M.-"Note alarm sounding. Upon entry into residents room observe resident to be siting on bottom with legs extended outward...Resident states 'I wanted to sit in my chair'...call light attached to bed resident is able to identify function of device and knows to call for assist...discussed with resident cause of event...." 1/09/11 at 11:00 A.M.-"Resident found sitting on fall matt (sic) at bedside in upright position. No alarm sounding-found unclipped on bed...." 1/19/11 at 7:20 P.M.-"Pt (patient) found on floor, sitting on buttocks, back against bed. Pt sitting on mat, placed bedside for safety purposes...while sitting on floor, Pt announced 'I need to pee'...." 1/25/11 at 3:40 A.M.-"While assisting resident in rm (room) (number) CNA (certified nursing aide) notified this nurse that resident on floor. Immediately assessed resident who I found lying on floor in his room, lying on his right side...noted bleeding from laceration to right forehead above right eye...2 cm (centimeters) long and 1 cm wide 1.5 cm deep. Resident stated he did not recall what happened, and why he attempted to ambulate. This nurse had checked on resident at 3:20 A.M. who at that time was resting in bed, low bed, floor mat and call lite was in place...." 1/25/11 at 5:00 A.M.-"Notified (Name) ambulance for resident transfer to ER (Emergency Room)...." 1/25/11 at 9:35 A.M.-"Pt (patient) came back from ER...3 sutures to R (right) eye and hematoma to R eye that is swollen...."	F 323		

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F 323	Continued From page 46 2/05/11 at 7:30 A.M.-"Resident found with legs on fall mat. Shoulders and head on bed. Alarm intact. Assisted to return to bed...bed alarm attached...." Resident # 3's most recent quarterly MDS (Minimum Data Set) assessment, dated 1/25/11, indicated he needed extensive assistance of one person for transferring and ambulation. It also indicated his mental status was severely impaired. Review of Resident # 3's Care Plan, dated 8/10/10 and updated 2/01/11, indicated, "Problem: (Resident # 3) is at risk for falls R/T (related to) decreased mobility...Interventions: ...08. Assist with transfers as needed...11. Falling Star Program...13. Check resident more frequently. 14. Check resident for incontinence Q (every) hour. 15. 15 minute checks." During interview with the Director of Nursing on 2/10/11 at 3:40 P.M., she indicated she could not determine which interventions were put in place after each fall "because it's not documented." "We don't even show the alarm as an intervention. I don't know when that was put into place." 2. The clinical record of Resident # 31 was reviewed on 2/07/11 at 2:00 P.M. and indicated diagnoses of, but not limited to: tracheostomy, gastrostomy tube, seizure disorder, and shortness of breath. Resident # 31 was observed lying in his bed on 1/31/11 at 10:30 A.M. His bed was elevated to waist height, approximately three feet up from the floor. A padded fall mat was observed lying on the	F 323		

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F 323	Continued From page 47 floor on the east side of his bed. Resident # 31 was observed to have a tracheostomy and unable to verbalize his needs. When queried if he had adjusted his bed to the observed height, he nodded in a negative manner. Resident # 31's bed remained at waist height during the following additional observations on 1/31/11: 12:25 P.M., 2:50 P.M. and 5:20 P.M. The bed height concern was brought to the attention of the Corporate Consultant on 1/31/11 at 5:30 P.M. Upon entering Resident # 31's room, she attempted to lower his bed by pushing the down arrow mounted on the foot-board of the bed. It failed to lower and it was determined at that time that the bed had been unplugged from the electrical outlet at some point during the day. The bed was plugged into an electrical outlet and lowered to the lowest position. During interview with the Corporate Consultant at the time of the 5:30 P.M. observation, she indicated maintenance would need to add an additional outlet to Resident # 31's room to accommodate his needs (Intravenous pump, suction machine, nebulizer, bed, etc.). The most recent quarterly MDS (Minimum Data Set) assessment, dated 1/31/11, indicated Resident # 31 needed an extensive assist of two staff tor transfers, dressing, eating, and bathing. A Care Plan, dated 11/03/10, indicated, "Problem: (Resident # 31) is at risk for falls R/T (related to) Hx (history) of falls, seizure disorder, compulsive behaviors...Approach: ...06. Mat at bedside when he is in bed, make sure pad overlaps bedside table for safety...08. Low bed and bed alarm...13.	F 323		

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F 323	Continued From page 48 Falling Star Program...." A Nurse's Note, dated 2/3/11 at 1:50 P.M., indicated, "Upon entry into room writer notes resident legs extended partially lying on floor with upper torso being held off floor by CNA. Per (3) lifted to bed...CNA (certified nursing aide) states that she was starting to transfer resident. Instructed him to wait but he continued got foot caught on feeding pole...." A facility policy titled "Falling Stars," revised 10/31/08, indicated, "Rationale: Falling Stars are used for residents identified at high risk for falls and/or with a history of falls (past or current). It establishes a common method of communication to remind staff to monitor these residents for fall prevention. It alerts staff to residents at risk for falls and who have approaches or interventions on their care plans to reduce and/or prevent repeat falls...Procedure: ...3. Update and/or implement Falling Stars interventions if the resident is identified at high risk or has a history of fall (past or current)...." 3.1-45(a)(1) 3.1-45(a)(2)	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	F 329 1. Residents #70 and #105's orders were clarified; assured heart rates were on the MARs. Residents #18, #42, and #14's pain levels were assessed and effectiveness of medication was evaluated, and no negative outcomes were noted.	3/12/11

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F 329	Continued From page 49 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure residents receiving anti-hypertensive (blood pressure) medications were within the physician's recommended parameters to receive the medication related to the assessment of the apical pulse (heart rate) for 2 Residents #70 and #105) of 15 residents reviewed with hypertension in a sample of 24 and failed to assess pain level and evaluate effectiveness of pain medication for 2 (Residents: #18, #42) of 6 residents in a supplemental sample of 10 and 1 (Resident # 14) of 7 residents in the sample of 24. Findings include: 1. Resident #105 record was reviewed on 2/1/11 at 9:00 a.m., and indicated diagnoses of, but not limited to: hypertension, atrial fibrillation, and hypothyroidism.	F 329	2. Residents receiving anti-hypertensive medications will have apical rates and blood pressures taken prior to receiving medications. Parameters will be followed with physician notification if applicable and documented. Residents receiving PRN pain medications will be assessed for appropriate documented interventions on the pain monitoring flow sheet pre- and post-pain. 3. Licensed staff will be re-educated on protocols for anti-hypertensive medications. Licensed staff will also be re-educated on non-pharmacological interventions, appropriate interventions pre- and post- documented results on the pain flow record. Unit Managers, or their designees, will audit MAR/Pain Flow Records daily for 2 weeks and then weekly thereafter. Any continued non-compliance will result in 1:1 re-education up to and including termination.	

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F 329	Continued From page 50 A Care Plan, dated 2/1/11, indicated, "Problem: "Cardiac output altered related to hypertension...Goal: "...Have no signs/symptoms of hypertension daily thru next review" Approach of: "medication-Metoprolol tartrate (anti hypertensive medication) : check apical (ap)-hold med if less than (<) or equal (=) 50 and contact doctor. " A current Physician's Order, dated 8/28/10, indicated, "Metoprolol Tartrate 25 milligram (mg) 1/2 tablet orally twice a day (bid)-check apical (ap)-hold med if less than (<) or equal (=) 50 and contact doctor. " The Medication Administration Record (MAR) was reviewed for the months of November 2010, December 2010, and January 2011 for apical pulse (ap) and indicated the facility failed to follow the physician order related to administration of the Metoprolol tartrate twice a day. Review of Nurse's Notes, Vital Sign Record, and Medication Administration Record (MAR) for November, and December 2010, January 2011 lacked documentation for the reason no apical pulses were performed. During an interview with the South Unit Manager LPN # on 2/1/11 at 10: 30 a.m., indicated the apical pulse assessment should have been performed prior to the administration of the the Metoprolol Tartrate and held when appropriate with documentation of the reason and contact the doctor. She indicated the apical pulse had not been performed.	F 329	4. Audits will be presented to the Executive Director for review and then forwarded monthly to the Performance Improvement Committee for further recommendations.	

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F 329	Continued From page 51 2. The clinical record for Resident # 70, reviewed on 1/31/11 at 10:45 A.M., indicated diagnoses of, but not limited to: bronchitis, congestive heart failure, diabetes mellitus, and hypertension. A Physician Order, dated 12/6/10, indicated, "...Carvedilol 3.125 mg (milligrams) 1 tab po (orally) BID (twice daily)-Hold if systolic blood pressure < (less than) 100 OR HR (heart rate) < 60..." Review of the December 24 through 31, 2010, MAR (Medication Administration Record), for 12 doses, lacked documentation of any blood pressure or heart rate readings to evaluate the need for Carvedilol. Review of the January 2011, MAR, for 62 doses, lacked documentation of heart rate readings to evaluate the appropriateness for Carvedilol. During an interview with the DNS (Director of Nursing Services) on 2/4/11 at 11:20 A.M., it was indicated that both the pulse and blood pressure should be evaluated prior to giving Carvedilol. The "2010 Nursing Spectrum Drug Handbook", indicated "...When drug is used to treat heart failure, check apical pulse before administering. If it's below 60 beats/minute, withhold dosage and contact prescriber...." A facility policy titled "Blood Pressure Measurement", revised 10/31/10, received on 2/2/11 at 12:05 P.M., "...Procedure... 17. Record the blood pressure in the patient's medical record. 18. If blood pressure out of range, notify physician and follow orders, if applicable...."	F 329		

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F 329	Continued From page 52 3. Resident # 14's clinical record was reviewed on 2/01/11 at 9:30 a.m. and indicated diagnoses of, but not limited to: debility, rheumatoid arthritis, and dysphagia. A Physician's Order, dated 12/04/10, indicated, "Morphine Sulfate 10 mg (milligram) liquid per G-tube (gastrostomy tube) TID (three times a day) PRN (as needed) for pain." Review of the Medication Administration Record (MAR), dated 2/01/11 through 2/28/11, indicated Resident # 14 had received the Morphine sulfate on 2/01/11. The February 2011 Pain Monitoring Flow Sheet and Nurse's Notes lacked documentation indicating the resident's pain level prior and post administration of the pain medication. They also lacked documentation of alternative measures prior to use of the pain medication. 4. Resident # 18's clinical record was reviewed on 2/03/11 at 11:10 A.M. and indicated diagnoses of, but not limited to: diabetes, hypertension, and history of traumatic fracture to lower leg. A Physician's Order, dated 1/05/11, indicated, "Ultram (Tramadol HCL) (pain medication) 50 mg tablet. 2 tabs P.O. (by mouth) TID PRN for pain." Review of the Medication Administration Record (MAR), dated 2/01/11 through 2/28/11, indicated Resident # 18 had received the Ultram on 2/03/11. The February 2011 Pain Monitoring Flow Sheet and Nurse's Notes lacked documentation indicating the resident's pain level prior and post	F 329		

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F 329	Continued From page 53 administration of the pain medication. They also lacked documentation of alternative measures prior to use of the pain medication. 5. The clinical record of Resident # 42 was reviewed on 2/03/11 at 11:20 A.M. and indicated diagnoses of, but not limited to: peripheral vascular disease, open wound of the leg, and history of embolism (blood clot) to the lower extremity. A Physician's Order, dated 11/18/10, indicated, "Tramadol HCL (pain medication) 50 mg tablet. 1 tab P.O. Q (every) 6 hours PRN for pain." Review of the Medication Administration Record (MAR), dated 2/01/11 through 2/28/11, indicated Resident # 42 had received the Ultram on 2/04/11. The February 2011 Pain Monitoring Flow Sheet and Nurse's Notes lacked documentation indicating the resident's pain level prior and post administration of the pain medication. They also lacked documentation of alternative measures prior to use of the pain medication.	F 329		
F 425 SS=D	3.1-48(a)(3) 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425	F 425 1. Resident #70's Osteoporosis medication will be given 1x monthly at 0500. Resident #70's hypothyroid medication will be given daily at 0600 to avoid incompatible interactions.	3/12/11

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F 425	Continued From page 54 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure incompatible medications were not administered at the same time for 1 (Resident #70) of 24 residents reviewed for medications in the sample of 24. Findings include: The clinical record for Resident # 70, reviewed on 1/31/11 at 10:45 A.M., indicated diagnoses of, but not limited to: osteoporosis, hypothyroidism, diabetes mellitus, and hypertension. A Physician Order, dated 12/6/10, indicated, "...Boniva 150 mg (milligrams) 1 tab po (orally) q (every) month on the 5th. Must give first thing in the morning on an empty stomach, 30 minutes before any other medication or food. Give with water only. Must remain upright for 30 minutes after dose is given...Levothyroxine Sodium 0.05 mg tablet 1 tab po qd (every day)..."	F 425	2. Residents receiving incompatible medications will receive those 60 minutes apart from each other. 3. Licensed staff will be re-educated on incompatible medications and appropriate timeframes. New admissions and re-admissions will be reviewed to assure incompatible medications are not administered together. MARs will be audited daily for 2 weeks, 3x weekly for 2 weeks, and then weekly thereafter. Any non-compliance will result in 1:1 re-education up to and including termination. 4. Audits will be presented to the Executive Director for review and will then be forwarded monthly to the Performance Improvement Committee for further recommendations.	

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F 425	Continued From page 55 Review of the January 2011, MAR (Medication Administration Record), indicated the Boniva and Levothyroxine were both scheduled and given on 1/5/11 at 0500 (5:00 A.M.). During an interview with LPN # 1, on 2/9/11 at 10:40 A.M., she indicated that all Boniva doses are ordered to be given at 0500 (5:00 A.M.). Interview with DON (Director of Nursing), on 2/4/11 at 11:20 A.M., she indicated that Boniva and Levothyroxine should not have been given together. The 2010 Nursing Spectrum Drug Handbook indicated for the drug Boniva, "...give oral dose...at least 60 minutes before...administering other oral drugs...."	F 425		
F 441 SS=E	3.1-25(b) 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	F 441 1. Resident #29 no longer resides at the facility. Resident #10's personal bottle is refilled at the nursing station with the use of small cups. Ice scoops are stored on the outside of the ice chest during water/ice pass. 2. Residents requiring isolation will have appropriate equipment (gloves, gowns, mask (if needed), BP cuff, stethoscope, and thermometer) placed in chest	3/12/11

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F 441	Continued From page 56 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure proper infection control practices were implemented related to removal of contaminated equipment from an isolated resident's room (Resident #29) while wearing contaminated gloves for 1 of 1 residents in isolation in the sample of 24, cross contamination of a community juice dispenser evidenced by the refilling of a resident's (Resident # 10) personal bottle for 1 of 1 in the supplemental sample of 10 with the potential of affecting 49 residents residing on the North Unit, and improper storage of the ice scoop in 2 of 2 ice chests on 2 units which had the potential of affecting 118 of 119 residents residing in the facility.	F 441	inside resident's room to assure that staff follows policy and procedures including appropriate hand washing. Plastic cups have been placed on the ice chest to store scoop inside during passing of ice/water. Extra small disposable drinking cups have been placed beside the juice dispenser if residents' personal bottles need to be filled. 3. Staff have been re-educated on the infection control policy and procedures relating to isolation, passing water and refilling or residents' personal water bottles. Residents in isolation: Unit Managers, or their designees, will observe staff to assure contamination does not occur 3x weekly for 2 weeks, 2x weekly for 2 weeks, and then weekly thereafter if applicable. Unit Managers, or their designees will observe ice/water pass, Monday through Friday for 2 weeks, to assure that the ice scoop is not left in the ice chest, then 3x weekly for 2 weeks, and then weekly thereafter. Unit Managers, or their designees, will monitor the juice dispenser	

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F 441	Continued From page 57 Findings include: During initial tour of the facility on 1/30/11 at 3:30 P.M., RN # 5 identified Resident # 29 as an isolation resident related to his diagnosis of Clostridium Difficile (C-diff) toxin. Review of Resident # 29's clinical record on 1/31/11 at 9:30 A.M., indicated diagnoses of, but not limited to: end-stage renal failure, hypertension, and C-diff. During observation of Resident # 29 on 1/31/11 at 2:40 P.M., CNA #12 entered his room and closed the door. She ignored the sign outside the room to wear a gown and gloves prior to entering the room. Two other staff (CNA # 14 and LPN # 8) gloved and gowned prior to entering the room to assist CNA # 12. CNA # 12, while wearing contaminated gloves, exited Resident # 29's room with a Hoyer lift. Draped over the top of the Hoyer lift was the contaminated cloth transfer saddle used to transfer Resident # 29 from his bed to his wheel chair. CNA # 14 and LPN # 8 removed their gloves and gowns in the room and washed their hands prior to exiting Resident # 29's room. CNA # 12 parked the contaminated Hoyer lift in the hallway, removed her contaminated gloves and disposed of them is the waste basket attached to the medication cart in the hallway. She then proceeded to obtain a clean blanket and returned to Resident # 29's room without gloving or gowning up. CNA # 12 was then observed leaning against Resident # 29's bed while she packed a bag lying on his bed. She the proceeded to his closet and collected his stocking cap, placed it on his head, opened a drawer on his bedside table and removed a	F 441	to assure that staff does not inappropriately fill personal water bottles. Any non-compliance will result in 1:1 re-education up to and including termination. 4. Results of audits will be presented to the Executive Director for review and then forwarded monthly to the Performance Improvement Committee for further recommendations.	

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F 441	Continued From page 58	F 441		

telephone with a wire and clipped it to his ear. She then left his room without washing her hands. She immediately proceed to another resident's room to provide care.

CNA #12 indicated in an interview at the time of the observation on 1/31/11, she was aware she needed to wash her hands after providing care to a resident. She further indicated she knew how easily C-diff could be transmitted from one resident to another, but she needed to help a co-worker provide care to another resident and forgot to wash her hands.

A facility policy titled "Transmission-Based Precautions," revised 10/31/09, indicated, Rationale: Transmission-Based Precautions are for residents with documented or suspected infection or colonization with highly transmissible or epidemiologically important pathogens for which additional precautions are needed to prevent transmission...Procedure: ...13. Place necessary equipment and supplies in the isolation room...16. Maintain isolation precautions until discontinued by the attending physician...."

2. Observation of the facility ice chests showed two separate occasions when the ice scoop was improperly stored in the ice chest. During observation on 2/7/11 at 2:10 P.M., an ice scoop used to dispense ice cubes was left in the ice chest which was full of ice on the South hall. This improper practice had the potential to affect 69 of 69 residents residing on the South hall. On 2/7/11 at 2:45 P.M., an ice scoop used to dispense ice cubes was left in the ice chest which was full of ice on the North hall. CNA # 3 was observed opening the ice chest and removing the scoop with ice in it, dispensing the ice cubes into a Resident's cup and then placing the scoop back

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F 441	Continued From page 59 into the ice chest. On 2/7/11 at 2:48 P.M., CNA # 4 filled a previously used plastic Sprite bottle from Resident # 10's room with grape drink from the community juice dispenser located at the nurses' station on the North Hall. The CNA put the neck of the plastic Sprite bottle up around the stationary spigot of the juice dispenser and filled it with grape drink then took it back to the room. These improper practices had the potential to affect 49 of 49 residents residing on the North hall. CNA # 2 indicated in an interview on 2/7/11 at 2:10 P.M., the ice scoop was to be kept in the bag that hangs on the outside of the chest. In an interview with CNA # 3 on 2/7/11 at 2:45 P.M., she indicated the ice scoop was to be kept in the plastic bag on the outside of the chest. During interview with CNA # 4 on 2/7/11 at 2:48 P.M., she indicated she was unaware of the protocol related to filling previously used cups or bottles. The DNS (Director of Nursing Services) indicated on 2/7/11 at 5:30 P.M., that clean, disposable cups are to be used to dispense juice from the community juice dispenser. A facility policy titled "Passing Ice Water to Residents," revised on 10/31/10, received on 2/7/11 at 5:10 P.M. from the DNS, indicated, "...Avoid leaving the ice scoop in the ice...store the ice scoop in a covered container..."	F 441		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY PLACE OF SOUTH BEND	52654 NORTH IRONWOOD ROAD SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 60 3.1-18(b)(2) 3.1-18(l)	F 441		